

# **ASSESSMENT/PLANNING PARAMETERS CONSISTENT WITH *OLMSTEAD* DECISION**

- ☐ Assessment and planning is not intended to determine “community readiness.” Rather, assessment and planning should start with, and seek to implement, the premise that people can live in the communities of their choice with appropriate supports and services. Assessment tools and/or planning processes must not act as artificial barriers to individuals moving swiftly to the community.
- ☐ States must assess each individual to determine the specific supports and services that are appropriate for the person and that he or she needs to live in, or remain in the community, including those needed to promote the individual’s community inclusion, independence and growth, health and well being. The composition of an assessment/planning team will vary depending on the person’s circumstances, needs and desires.
- ☐ The individual assessment/planning process should be “person-centered” and focus on the person’s goals, desires, cultural and language preferences, abilities and strengths as well as relevant health/wellness/ behavioral issues and skill development/training needs. It should not focus primarily on the person’s diagnosis or clinical condition.
- ☐ People should always be involved in their own assessment/planning process and must be provided with information in a form they can understand to help them make choices and consider options. Information on options for living arrangements, meaningful day activities, including work, and integrated leisure opportunities should be included. Experiential information – visits to community options – will be necessary for many individuals with disabilities.
- ☐ People should not be required to make a decision about moving to the community before the assessment/planning process begins. Such decisions cannot be made until the individual understands the options possible for him or her. People are free to choose reasonable risks.

- ☐ Family members, friends or support people have an important role in the assessment/planning process, to the extent desired by the person with a disability, but cannot be allowed to “veto” the person’s movement to the community.
- ☐ People must have the supports which best enable them to communicate, e.g., communication devices or the presence of people who can best interpret for them. For individuals whose communication of abstract choices is difficult to understand, the assessment/planning process should include gathering information on the person’s preferences and needs from the people who know the individual best. Independent advocates should be provided for such individuals.
- ☐ Peer support and/or independent advocates should be available to assist individuals in the assessment/planning process.
- ☐ Professionals who prepare assessments and/or participate in planning must be qualified. In order to be qualified, a professional must have knowledge in their field of relevant professional standards and core competencies related to community-based services. At each assessment or planning meeting, a professional must be present with knowledge of the full variety of community living arrangements including the most integrated options, and of the capacities of community systems to meet even the most challenging or complex needs. Even if such options are not currently available in the geographic area they must be considered in the assessment and planning process.
- ☐ Institutional staff should never be the only ones preparing assessments or determining the content of plans. Rather, professionals who work in the community—e.g., Centers for Independent Living or other community organizations or experts that provide or design community-based support—must be involved in assessment and planning. (Clinical and direct care staff from institutions often have little or no knowledge of community options and have a stake in the institution’s existence.)

- ☐ Assessments and determinations as to the most integrated setting must be based on the individual person's needs and desires for community services and not on the current availability or unavailability of services and supports in the community.
- ☐ It is common for state "professionals" to judge an individual "not ready" for the community solely because there is no community placement currently available for that individual. Guidelines used by states for placement into the community or particular community programs should not be factors in determining whether an individual can be served in the community with appropriate supports. Such guidelines are typically developed without consideration for the affirmative requirement of the ADA as interpreted in *Olmstead*. Instead, they reflect a "priority" system, which arbitrarily limits community services to a very limited number out of many individuals who could appropriately live in the community or simply reflects the lack of community supports, including crisis services. Whether appropriately crafted services are currently available in the local community has no bearing on whether the community is the most integrated setting appropriate for an individual.
- ☐ Individuals must be given understandable information about the results of their assessments and plans, in writing, and sign off on these documents. If an individual is unsatisfied with recommendations made or results, she or he must have the right to appeal and be informed of how to do so.
- ☐ Assessments should clearly identify the range of services needed and preferred to support the person in the community, in all relevant areas, including where appropriate, housing, residential supports, day services, personal care, transportation, medical care, and advocacy support.
- ☐ Once the necessary components of a community setting are agreed upon, the plan must identify how those services and supports will be provided and specify the date community support will begin. Clarity as to who is responsible to connect the individual with community providers and assist in transition activities is necessary.

- ☐ When some or all the services needed to support a person at home or in the community are currently "unavailable," the "unmet needs" must be documented and the person should be promptly referred and placed on all applicable waitlists. Such documentation should include the type and amount of services needed, the reasons for the shortage (if known) and the individual's preferences among possible options.
- ☐ Aggregate data on unmet needs and the lack of availability of needed home and community options, services and housing must be maintained and used for systemic planning and resource development purposes.
- ☐ Resource development activities must be undertaken to address the service gaps that result in "unmet needs" including, e.g., expansion of federal funding resources, and widening of eligibility, recruitment of new service providers, raising wages for direct support staff and clinical resources to increase their availability and quality. Clarity as to who is responsible for resource development and the anticipated timeline is necessary.
- ☐ The outcome of the assessment/planning process should be: The transition of people to community living will be responsive to individual needs, circumstances and preferences, and significant numbers of people will be able swiftly to move to community settings. People at risk of institutionalization will receive supports they need to maintain their lives in the community. Community crisis services will be available to prevent institutionalization.

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